(11)

No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS VACCO AND PATAKI

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QUESTIONS PRESENTED

1. Whether, under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, terminally ill, mentally competent patients who do not require artificial life support and who want to commit suicide with the assistance of a physician are similarly situated to terminally ill, mentally competent patients who are or can be kept alive only by means of life-sustaining medical treatment, which they are free to refuse or terminate.

2. Whether a state retains a legitimate interest under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution in prohibiting physician assisted suicide while allowing terminally ill, mentally competent patients to refuse or discontinue artificial life support.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit (J.A. 215)[2] is reported at 80 F.3d 716 (2d Cir. 1996). The opinion of the United States District Court for the Southern District of New York (J.A. 195) is reported at 870 F.Supp. 78 (S.D.N.Y. 1994).

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[1] Petitioner Robert M. Morgenthau, although separately represented, joins in this brief.

[2] References to the joint appendix filed with this brief are cited as (J.A.).

JURISDICTION

The decision of the United States Court of Appeals for the Second Circuit was rendered, and judgment entered, on April 2, 1996. This Court has jurisdiction to hear this appeal under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, and New York Penal Law §§ 125.15(3) and 120.30.

The Fourteenth Amendment provides in pertinent part:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. amend. XIV, § 1.

Penal Law § 125.15(3) is entitled "Manslaughter in the second degree" and provides in pertinent part:

> A person is guilty of manslaughter in the second degree when . . . (3) He intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony.

N.Y. Penal Law § 125.15(3) (McKinney 1987).

Penal Law § 120.30 is entitled "Promoting a suicide attempt" and provides:

> A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony.

N.Y. Penal Law § 120.30 (McKinney 1987).

STATEMENT OF THE CASE

Advocating a radical departure from the established precedents and traditions of the State of New York and of this nation, plaintiffs-respondents ("plaintiffs") brought this case to urge recognition of a constitutional right for terminally ill patients to have the aid of a physician in committing suicide. Plaintiffs are three physicians who, together with three terminally ill patients,[3] commenced suit against the New York Attorney General[4] pursuant to 42 U.S.C. § 1983 to contest the constitutional validity of New York Penal Law §§ 125.15(3) and 120.30, which make criminal the acts of causing or aiding another to commit suicide or to attempt suicide (J.A. 21).

Plaintiffs allege that the "Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives" (J.A. 26), that the right to assisted suicide is a fundamental right (J.A. 27), and that New York's laws are unconstitutional under the Due Process Clause (J.A. 27). They also assert that because terminally ill people may request the withdrawal of life-sustaining treatment, the prohibition of

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[3] The plaintiff-patients, Mr. William A. Barth, Ms. Jane Doe, and Mr. George A. Kingsley, died by the time the district court rendered its opinion, leaving only the physicians as appellants before the Second Circuit and respondents before this Court.

[4] Former New York State Governor Mario M. Cuomo and Manhattan District Attorney Robert M. Morgenthau were added as parties by amendments to the complaint filed in October 1994. Dennis C. Vacco and George E. Pataki were substituted in the action following their succession to the offices of Attorney General and Governor, respectively, in 1995.

physician assisted suicide violates the rights, under the Equal Protection Clause, of those patients who are terminally ill but are not on artificial life support (J.A. 27). Plaintiffs seek a judgment authorizing physicians to furnish prescriptions for lethal medication to patients, which patients would then self-administer to cause their deaths (J.A. 28).

Suit was commenced in July 1994. In September 1994, plaintiffs moved for a preliminary injunction, in support of which they submitted affidavits that described, in detail, the suffering each plaintiff-patient had endured as a consequence of the illnesses that afflicted them. Patient Barth, in his affidavit (J.A. 96), stated that he suffered from several AIDS-related diseases, including cytomegalovirus, microsporidiosis, pneumonia, cryptosporidiosis, and microbacterium avium. The treatments Mr. Barth employed to combat the symptoms of his illnesses, such as daily infusions and overnight intravenous feeding, themselves caused serious negative side effects. Patient Jane Doe, in her affidavit (J.A. 105), stated that she suffered from thyroid cancer, which by the time of suit had caused a large cancerous tumor to wrap itself around her carotid artery, making it necessary to implant a feeding tube in her stomach which itself caused serious negative side effects. Ms. Doe was unable to take sufficient pain medication to achieve comfort while remaining mentally alert. Patient George A. Kingsley submitted an affidavit (J.A. 99) stating that he was afflicted with AIDS-related diseases including cryptosporidiosis, cytomegalovirus retinitis (leading to blindness in one eye), and toxoplasmosis. Mr. Kingsley self-administered medications through painful injections, and other infusions were administered daily through a tube connected to an artery in his chest.

All three patients expressed in their affidavits a desire for "certain death," to be achieved through the intervention of their physicians (J.A. 98, 102, 108). Fear of exposing their physicians to criminal sanction, however, kept the plaintiff-patients from committing suicide with their doctors' assistance (J.A. 102), while fear of exposing themselves to criminal sanctions kept the plaintiff-physicians from rendering such aid (J.A. 46, 71, 88). All of the plaintiff-patients, during the course of this litigation, died of the underlying diseases that afflicted them. The State of New York did not contest below, nor does it contest now, the depth of the suffering experienced by these plaintiff-patients.

Also submitted to the court below was the affidavit of plaintiff-physician Timothy Quill, M.D., describing the medical interventions which typically take place when patients refuse to continue life-sustaining medical treatment and opining that "[w]hen such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live" (J.A. 116). As stated by Dr. Quill, "[w]hile death from dehydration and starvation is acceptable to some of our patients, others ask us why they must endure such an ordeal when it can only end in their death, especially when there are alternatives available that could ease death more humanely" (J.A. 118).

In response to the motion for a preliminary injunction, defendants-petitioners cross-moved for dismissal on the pleadings. In an opinion dated December 15, 1994 (J.A. 195), Chief Judge Griesa of the United States District Court for the Southern District of New York treated the cross-motion to dismiss as one for summary judgment (J.A. 197), and held on the merits that the criminalization of physician assisted suicide involves neither a denial of a fundamental liberty interest protected by the Fourteenth Amendment's Due Process Clause nor a denial of equal protection under that same Amendment (J.A. 207-09).

On appeal, the Second Circuit affirmed that portion of the district court's opinion which found no substantive due process right to assisted suicide, concluding that "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design" (J.A. 233). The court found, however,

that New York's prohibition of physician assisted suicide violates the Equal Protection Clause, holding that physician assisted suicide is no different than the withdrawal of life-sustaining medical treatment, that the State of New York has no legitimate interest that justifies the "prolongation of a life that is all but ended," and that no rational basis exists to support New York's disparate treatment of the two (J.A. 245). On this basis, the court invalidated New York Penal Law §§ 125.15(3) and 120.30 to the extent that those laws impose criminal penalties on physicians who prescribe lethal dosages of medication for their terminally ill, mentally competent patients to self-administer in order to commit suicide (J.A. 249).

A concurring opinion (Calabresi, J.) agreed that the statutes were "constitutionally suspect" but recommended that New York's penal provisions on assisted suicide be sent back to the New York State Legislature on "constitutional remand" for full consideration and a clear articulation of the state interests involved should the Legislature re-enact the statutes (J.A. 265).

On October 1, 1996, this Court granted certiorari, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 95-1858), to decide the equal protection questions presented.

SUMMARY OF ARGUMENT

The Second Circuit erred in concluding that terminally ill patients who exercise a right to forego or withdraw from artificial life support are, for equal protection purposes, similarly situated to those who are also terminally ill, have no equivalent life-sustaining treatment to forego, and want a physician's assistance in committing suicide. As this Court recognized in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), the right to forego treatment derives from the common law right to bodily integrity and freedom from unwanted physical intrusions. The asserted

"right" to physician assisted suicide is, by contrast, a right to demand outside assistance in the taking of one's own life.

The distinction between acts that artificially sustain life and those that artificially end life is reflected in *Cruzan* as well as in the laws of nearly every state, which provide for the refusal or termination of medical treatment but expressly prohibit assistance in suicide. It is also reflected in medical practice and medical ethics, which generally permit withdrawal of treatment but forbid a physician's assistance in a patient's suicide. These legal and medical distinctions are rooted in logical differences between refusal or termination of treatment and assisted suicide.

New York's prohibition of assistance in suicide also withstands equal protection scrutiny because it is rationally related to legitimate state interests. The ban reflects the State's interest in prohibiting intentional killing and protecting human life and its unwillingness to make judgments as to the value of life based on the "quality" of life experienced by its citizens. The Second Circuit's equal protection analysis, although ostensibly limited to terminally ill patients, is not so readily contained and could be employed to extend a right of assisted suicide to patients who are not terminally ill and to those who are not ill at all.

New York's prohibition of assisted suicide also is legitimately related to its interest in protecting vulnerable patients from mistake and abuse. There is a direct correlation between inadequate control of pain in medical treatment and patient requests for suicide. Especially with the advent of managed care and other cost control measures in medicine, there is a danger that the quick death offered by legalized suicide will be preferred to costly treatment and proper pain management, a risk which is enhanced for the poor and the elderly, who are likelier than others to suffer from inadequate pain relief. Moreover, any efforts to establish regulations governing and limiting the practice of assisted suicide are likely to founder

upon the confidentiality of the physician-patient relationship. Regulation of physician assisted suicide will inevitably be a matter of physician self-regulation.

The Second Circuit erred in its equal protection analysis, thereby arrogating to itself the decision that doctors may help their patients kill themselves. The question of whether physician assisted suicide should be prohibited, however, is one of legislative dimension, not constitutional imperative.

ARGUMENT

As the Second Circuit noted (J.A. 234), the Equal Protection Clause requires that " 'all persons similarly circumstanced shall be treated alike,' " but " 'does not require things which are different in fact or opinion to be treated in law as though they were the same.' " *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (citations omitted). Moreover, "[u]nless a statute provokes 'strict judicial scrutiny' because it interferes with a 'fundamental right' or discriminates against a 'suspect class,' it will ordinarily survive an equal protection attack so long as the challenged classification is rationally related to a legitimate governmental purpose." *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 457-58 (1988) (citations omitted). Only a statute that treats "similarly circumstanced" people differently without sufficient justification violates the Equal Protection Clause.

The Second Circuit's equal protection inquiry was conceptually legitimate but analytically flawed. Most importantly, the court failed to recognize that, whether viewed as a matter of precedent in law and practice in medicine or as a matter of logic, competent, terminally ill patients who want a physician's assistance in committing suicide are not similarly situated to their counterparts "who are on life-support systems" (J.A. 243-44). Nor did the court, despite holding correctly that the asserted right to assisted suicide is not

fundamental and thus is subject only to rational basis scrutiny, recognize the rational relationship between New York's statutes criminalizing assisted suicide and the legitimate purposes that underlie those statutes.

POINT I

TERMINALLY ILL PATIENTS ON LIFE SUPPORT WHO NO LONGER WANT THEIR LIVES SUSTAINED BY ARTIFICIAL MEANS AND TERMINALLY ILL PATIENTS WHO ARE NOT ON LIFE SUPPORT AND WANT TO "HASTEN DEATH" BY COMMITTING SUICIDE ARE NOT SIMILARLY SITUATED

The Second Circuit committed a central error when it concluded that terminally ill patients whose lives have been sustained by artificial means but who no longer want such treatment and terminally ill patients who are not on life support and wish to "hasten death" by committing suicide are similarly situated. The legal status of the two groups differs, as does the accepted medical practice with respect to each. Moreover, there are important logical and factual distinctions between "acts that artificially sustain life and acts that artificially curtail life." *People v. Kevorkian*, 527 N.W.2d 714, 728 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995).

A. The Second Circuit's Reliance on *Cruzan* Was Misplaced

This Court, in its leading decision in this area, in fact has already recognized that the nature of the right that entitles a patient to refuse or terminate artificial life support differs from that of the asserted right of a terminally ill patient to receive assistance in committing suicide. *Cruzan v Director, Missouri Department of Health*, 497 U.S. 261 (1990), presented the question of whether an individual in a persistent vegetative state possesses a substantive due process right to

the withdrawal of life-sustaining medical treatment. While stopping short of declaring a constitutional right to withdraw from such treatment, *see id.* at 279, this Court made clear its belief that such a right, whether or not of constitutional dimension, derives from the common law principle of bodily integrity and the entitlement of the individual to be free from interference with his or her person. The Court noted that "[a]t common law, even the touching of one person by another without consent and without legal justification was a battery." *Id.* at 269. Moreover, "[t]his notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment." *Id.* The "logical corollary" of this requirement "is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 270. *See also id.* at 287 (O'Connor, J., concurring) ("the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body"); *id.* at 305 (Brennan, J., dissenting) (equating "freedom from unwanted medical attention" and right "to determine what shall be done with one's own body").

While recognizing the right (whether constitutional or not) to refuse or withdraw from life-sustaining treatment, *Cruzan* nevertheless observed that "there can be no gainsaying" a state's "interest in the protection and preservation of human life," as demonstrated by the fact that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Id.* at 280. At the very moment, then, that it recognized a right to refuse treatment, this Court took pains to acknowledge the power of a state to ban assisted suicide outright. The Court thus demonstrated its understanding that refusal of treatment and assisted suicide are different things, supported by different legal principles.[5]

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[5] *See also* L. Tribe, *American Constitutional Law*, § 15-11, at 1370-71 (2d ed. 1988):

> The right of a patient to accelerate death as such—rather than merely to have medical procedures held in abeyance so that disease processes can work their natural course—depends on a broader conception of individual rights than any contained in common law principles. A right to determine when and how to die would have to rest on constitutional principles of privacy and personhood or on broad, perhaps paradoxical, conceptions of self-determination.

The Second Circuit erred by failing to distinguish the right of "a competent person [to] order the removal of life-support systems" (J.A. 241), which, following *Cruzan*, is based on the right to be free of bodily interference, from the asserted "right" of a terminally ill patient to assistance in suicide. The heavy reliance of the court below on *Cruzan* was misplaced because the right *Cruzan* recognizes does not embrace or suggest the "right" the Second Circuit announced. A person who seeks a physician's help in committing suicide is asserting not a right to be free of unwanted physical intrusions, but a right to insist on outside intervention in achieving a desired end. As *Cruzan* illustrates, the distinction is significant. *Accord Kevorkian*, 527 N.W.2d at 728 ("[i]n *Cruzan*, the Court was able to 'assume' a protected liberty interest in the withdrawal of life-sustaining medical treatment because it was able to distinguish between acts that artificially sustain life and acts that artificially curtail life. . . . [S]ome suggest that this is a distinction without constitutional significance . . . the *Cruzan* majority disagreed and so do we").

B. Termination of Life Support and Physician Assisted Suicide Are Legally and Medically Different

Until the decisions below and in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.) (en banc), *cert. granted*, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 96-110), this distinction was universally observed in American law. Thus, at least forty-four states which recognize the right to refuse treatment expressly disapprove of assisted suicide in statutes providing for the exercise of that refusal right,[6] and

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[6] Ala. Code § 22-8A-10 (1990); Alaska Stat. § 18.12.080(f) (1994); Ariz. Rev. Stat. Ann. § 36-3210 (1995 Supp.); Ark. Code Ann. § 20-17-210(g) (1991); Cal. Health & Safety Code § 7191.5(g) (West

at least thirty-five states ban assisted suicide by separate statute.[7]

Supp. 1996); Colo. Rev. Stat. § 15-18-112(1) (1987); Act of July 12, 1982, 63 Del. Laws 821 (1981); Fla. Stat. Ann. § 765.309(1) (West 1996 Supp.); Ga. Code Ann. § 31-32-11(b) (1994); Haw. Rev. Stat. § 327D-13 (1992 Supp.); Idaho Code § 39-152 (Supp. 1996); Ill. Comp. Stat. Ann. ch. 755, §§ 35/9(f), 40/50 (Smith-Hurd 1992); Ind. Code Ann. §§ 16-36-4-19, 16-36-1-12(c), 16-36-1-13, 30-5-5-17(b) (Burns 1993 & Supp. 1996); Iowa Code Ann. §§ 144A.11.6, 144B.12.2 (West 1989 & Supp. 1996); Kan. Stat. Ann. § 65-28.109 (1992); Ky. Rev. Stat. Ann. § 311.639 (Michie/Bobbs-Merrill 1995); La. Rev. Stat. Ann. tit. 40, § 1299.58.10(A) (West 1992); Mass. Gen. Laws Ann. Ch. 201D, § 12 (West 1996 Supp.); Me. Rev. Stat. Ann. tit. 18-A, § 5-813(c) (1995 Supp.); Md. Health-Gen. Code Ann. § 5-611(c) (1994); Mich. Comp. Laws Ann. § 700.496(20) (West 1995); Minn. Stat. Ann. § 145B.14 (West 1996 Supp.); Miss. Code Ann. § 41-41-117(2) (1993); Mo. Ann. Stat. § 459.055(5) (Vernon 1992); Mont. Code Ann. § 50-9-205(7) (1995); Neb. Rev. Stat. § 20-412(7) (1995); Nev. Rev. Stat. Ann. § 449.670(2) (Michie 1991); N.H. Rev. Stat. Ann. § 137-H:13 (1995 Supp.); N.Y. Pub. Health Law § 2989(3) (McKinney 1993); N.C. Gen. Stat. § 90-320(b) (1993); N.D. Cent. Code §§ 23-06.4-01, 23-06.5-01 (1991); Ohio Rev. Code Ann. § 2133.12(D) (Anderson 1994); Okla. Stat. Ann. tit. 63, § 3101.12(G) (West 1996 Supp.); Pa. Cons. Stat. Ann. tit. 20, § 5402(b) (Purdon 1996 Supp.); R.I. Gen. Laws §§ 23-4.10-9(f), 23-4.11-10(f) (1995 Supp.); S.C. Code Ann. § 44-77-130 (Law. Co-op 1993 Supp.); S.D. Codified Laws Ann. § 34-12D-20 (1994); Tex. Health & Safety Code Ann. § 672.020 (Vernon 1992); Utah Code Ann. § 75-2-1118 (1993); Va. Code Ann. § 54.1-2990 (1994); Wash. Rev. Code Ann. § 70.122.100 (1996 Supp.); W. Va. Code § 16-3-10 (1995); Wis. Stat. Ann. § 154.11(6) (West 1989); Wyo. Stat. §§ 3-5-211, 35-22-109 (1994 & Supp. 1996).

[7] Alaska Stat. § 11.41.120(a)(2) (1989); Ariz. Rev. Stat. Ann. § 13-1103(A)(3) (1995 Supp.); Ark. Code Ann. § 5-10-104(a)(2) (1993); Cal. Penal Code § 401 (West 1988); Colo. Rev. Stat. § 18-3-104(1)(b) (1995 Supp.); Conn. Gen. Stat. Ann. § 53a-56(a)(2) (1994); Del. Code Ann. tit. 11, § 645 (1995); Fla. Stat. Ann. § 782.08 (West 1992); Ga. Code Ann. § 16-5-5(b) (1994); Ill. Comp. Stat. Ann. ch. 720, § 5/12-31(a)(2) (Smith-Hurd 1996 Supp.); Ind. Code Ann. § 35-42-1-2.5(b) (Burns 1996 Supp.); Iowa S.F. 2066, to be codified as Iowa Code § 707A.2 (1996 Supp.); Kan. Stat. Ann. § 21-3406 (1995); Ky. Rev. Stat. Ann. § 216.302 (Michie/Bobbs-Merrill 1995); La. Rev. Stat. Ann. tit. 14, § 32.12 (West 1996 Supp.); Me. Rev. Stat. Ann. tit. 17-A, § 204 (1983); Minn. Stat.

Since the very first state decision authorizing termination of life support, *In re Quinlan*, 355 A.2d 647, 655 (N.J.) (recognizing "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support"), *cert. denied*, 429 U.S. 922 (1976), state courts, like state legislatures, have explicitly recognized a legal distinction between refusal of treatment and assisted suicide. *See, e.g., Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("a necessary distinction exists between a person suffering from a life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her demise and attempts to enlist the assistance of others"); *Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act"); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) ("there is a substantial difference between the attitude of a person desiring non-interference with the natural con-

Ann. § 609.215 (West 1987 and Supp. 1996); Miss. Code Ann. § 97-3-49 (1994); Mo. Ann. Stat. § 565.023.1(2) (Vernon 1996 Supp.); Mont. Code Ann. § 45-5-105 (1995); Neb. Rev. Stat. § 28-307 (1995); N.H. Rev. Stat. Ann. § 630.4 (1986); N.J. Stat. Ann. § 2C:11-6 (West 1995); N.M. Stat. Ann. § 30-2-4 (1994); N.Y. Penal Law §§ 120.30, 125.15(3) (McKinney 1987); N.D. Cent. Code § 12.1-16-04 (1995 Supp.); Okla. Stat. Ann. tit. 21, §§ 813, 814, 815 (West 1983); Or. Rev. Stat. § 163.125(1)(b) (1993) (although Oregon allows physician-assisted suicide under certain circumstances, *see* Or. Rev. Stat. §§ 127.800-127.897 (1996), assisted suicide remains generally illegal); Pa. Cons. Stat. Ann. tit. 18, § 2505(b) (Purdon 1983); R.I. Pub. Act 96-133, to be codified as R.I. Gen.Stat. tit. 11, ch. 60; S.D. Codified Laws Ann. § 22-16-37 (1988); Tenn. Code Ann. § 39-13-216 (1995 Supp.); Tex. Penal Code Ann. § 22.08 (Vernon 1994); Wash. Rev. Code Ann. § 9A.36.060 (1988); Wis. Stat. Ann. § 940.12 (West 1996). In *Compassion in Dying v. Washington*, 79 F.3d at 793-94, the Ninth Circuit held that the portion of the Washington statute prohibiting assisted suicide "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment."

sequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987) (a "decision to live without artificial life-sustaining procedures would not constitute suicide"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient"); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) ("[i]n the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide").

The legal distinction between refusal of treatment and suicide is paralleled by a medical distinction. The American Medical Association, the American College of Physicians, and the American Geriatrics Society all "consistently distinguish assisted suicide and euthanasia from the withdrawing or withholding of treatment." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 108 & n.111 (1994). *See also* Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2230-31, 2233 (1992) (while "[t]he withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence," assisted suicide "is contrary to the prohibition against using the tools of medicine to cause a patient's death"); American Geriatrics Society Policy Committee, *Voluntary Active Euthanasia Position Statement*, 39 J. Am. Geriatrics Society 826 (1991) (same). Medical ethicists also insist on the difference between termination of treatment and assisted suicide. *See* W. Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139, 2139 (1988) ("[g]enerations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments

(or allowing to die) and active, willful, taking of life"); Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 129 (1987) ("[m]edical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death by assisting suicide").[8] The rank and file of the medical profession likewise observes the distinction. *See* M. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatment*, 83 Am. J. Pub. Health 14, 17 (Jan. 1993) (survey shows 87% of hospital physicians and nurses agree with the statement that "to allow patients to die by foregoing or stopping treatment is ethically different from assisting in their suicide").

C. The Distinctions Are Grounded in Logic

The legal and medical distinctions between refusal or termination of treatment and assisted suicide are not arbitrary. Rather, they are rooted in at least three real logical differences between the two practices. First, they may be distinguished on the basis of intention of both physician and patient. As one expert puts it, a physician who withdraws treatment intends "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them," whereas a physician who assists a suicide "must, necessarily and indubitably, intend primarily that the patient be made dead." L. Kass, *Ethical Issues in Assisted Suicide*, Testimony Before Oversight Hearing on Assisted Suicide of House Committee on Judiciary, Subcomm. on the Constitution (April 29, 1996) at 16.[9] Similarly, a person who

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[8] The Hastings Center is "America's preeminent institute for the study of medical ethics." E. Larson, *Seeking Compassion in Dying*, 18 Seattle U. L. Rev. 509, 517 (1995).

[9] Assisted suicide is distinguishable from palliative treatment that may result in the patient's death, which is encompassed by the doctrine of "double effect." The intent of palliative treatment is to relieve pain and suffering, even though death may be a possible side effect of the treatment. While medication may, for example, in some cases depress res-

terminates treatment may face death as a likely result, but his purpose may be not death but, for example, the avoidance of invasive medical technology or prevention of treatments that conflict with sincerely-held religious beliefs. By contrast, a person who commits or obtains assistance in committing suicide intends to take his own life; he has a specific intent to die. Several courts have based the distinction between refusal or termination of treatment and assisted suicide on the different intent that underlies each. *See Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (people who refuse life-sustaining treatment "may not harbor a specific intent to die," but may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering"); *Saikewicz*, 370 N.E.2d at 426 n.11 ("in refusing treatment the patient may not have the specific intent to die"); *Satz v. Perlmutter*, 362 So.2d 160, 162-167 (Fla. Ct. App. 1978) (the fact that the patient "really wants to live, but * * * under his own power," precludes "his further refusal of treatment being classed as attempted suicide"), *aff'd*, 379 So.2d 359 (Fla. 1980).

Refusal or withdrawal of treatment and assisted suicide may also be distinguished based upon the difference between

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piration and thus lead to death, it is administered solely for pain relief, but with the patient's knowledge and acceptance of the risk of death. See Council on Ethical and Judicial Affairs, American Medical Association, *Physician-Assisted Suicide* (Report 8), App. C, at 2 (Dec. 1993); *see also id.* at 3 ("[t]he relief of suffering is an essential part of the physician's role as healer").

Analytically and medically, acceptance of palliative treatment that may result in death is no different from the knowing acceptance of the risk of death that accompanies many medical treatments, such as the risk of death attendant on a quadruple bypass. If the patient's death results from the surgery, the surgeon is not responsible for the death, nor does he intend it, even though it technically occurred at his hands. The indicated treatment—intended for the patient's well-being and undertaken with the patient's informed consent—simply was not successful. J. Arras, *News From the Circuit Courts: How Not to Think About Physician Assisted Suicide*, 2 BioLaw S:171, S:181 (July-Aug. 1996).

action and inaction. As one court has said, assisted suicide involves "affirmative, assertive, proximate direct conduct, such as furnishing" an instrumentality of death, and thus differs from the "presence of a doctor during the exercise of his patient's" right to refuse treatment. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986). It is true that one member of this Court, on whose opinion the court below relied (J.A. 243), has questioned "the action-inaction distinction," finding no legal difference from the patient's perspective between submitting to death and seeking it. *See Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring). As applied to the physician, however, the distinction is "deeply rooted in the law of negligence," which distinguishes between "active misconduct" or "misfeasance" and "passive inaction" or "nonfeasance." *Kevorkian*, 527 N.W.2d at 728. *See also* G. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 Seattle U.L. Rev. 473, 479 (1995) ("the duty not to commit a battery does not generate a duty to rescue; a duty not to touch does not generate a duty to render aid"). Although the distinction will not always be clear-cut, there is an obvious moral distinction between "originat[ing] a fatal sequence" and "allow[ing] one to run its course." *See* P. Foot, *Killing and Letting Die*, in *Abortion: Moral and Legal Perspectives* 177, 180 (J. Garfield and P. Hennessey eds., 1984). Assisted suicide, in other words, "involves not *letting* the patient die, but *making* the patient die." S. Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* 236 (1993) (emphasis in original). The distinction is honored by the established difference between acting to bring about a death through assisting a suicide and allowing one to occur through refusal or withdrawal of life-sustaining treatment.

Perhaps the clearest distinction underlying the different status of refusal or withdrawal of treatment and assisted suicide is based on causation. A patient who declines or withdraws from life-sustaining treatment is letting nature take its course.

His death is caused by the underlying disease or disorder, not by some intervention unrelated to it. "[T]here must," in other words, "be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology." D. Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* 77 (1993). Numerous courts have recognized this distinction. *See, e.g., Kevorkian*, 527 N.W.2d at 728 ("suicide involves an affirmative act to end a life," whereas refusal or withdrawal of treatment "allows nature to proceed"); *Conroy*, 486 A.2d at 1224 (contrasting "allow[ing] the disease to take its natural course" and "self-inflicted injury").

Contrary to the view of the court below (J.A. 215), this is true regardless of whether the underlying pathology is the organic cause of death or whether it imposes some disability that leads inexorably to death. It is thus of no consequence whether, for example, the withdrawal of Nancy Cruzan's artificial hydration and nutrition led to her death due to "an underlying disease" or to starvation. Her persistent vegetative condition and resulting inability to eat caused her death. By contrast, if she had been injected with a lethal dose of drugs, the drugs alone would have resulted in her death. *See* G. Annas, *The "Right to Die" In America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 Duquesne L. Rev. 875, 895-96 (1996) (distinguishing "real causes of death from the existence of various medical tools that may temporarily substitute for particular bodily functions").

Terminally ill patients who exercise a right to forego life-sustaining medical treatment are thus not in the same position as those who are also terminally ill, have no equivalent life-sustaining treatment to forego, but want a physician's assistance in committing suicide. The right to decline or withdraw from treatment derives from the common law right of bodily integrity. No such right underlies assisted suicide, which involves more than simply being let alone. The law has not treated the two classes of patients as similar, and long-standing medical practices distinguish between the two situations. The distinction, moreover, is supported by logical differences based on intent, causation and action/omission. The Second Circuit accordingly erred in concluding that the patients are "similarly circumstanced" (J.A. 243), and that their different treatment by the law can give rise to an equal protection violation.

POINT II

NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS SUPPORTED BY LEGITIMATE STATE INTERESTS

The case for physician assisted suicide, based as it is on instances of individual suffering, rests on what John Arras has called the "twin pillars of patient autonomy and mercy." J. Arras, *News from the Circuit Courts*, 2 BioLaw at S: 175. Dr. Arras notes:

> Many people advocate legalization [of physician assisted suicide] because they fear a loss of control at the end of life. They fear falling victim to the technological imperative; they fear dying in chronic and uncontrolled pain; and they fear the psychological suffering attendant upon the relentless disintegration of the self. They fear, in short, a bad death.

Id. at S: 174.

Juxtaposed against these real fears, the methodology of equal protection sounds formulaic at best. Nonetheless, as the Second Circuit recognized (J.A. 238), in order to survive equal protection scrutiny, New York's prohibition of assisted suicide need only be "rationally related to a legitimate state interest." *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 440 (1985). Because the New York laws neither involve a suspect classification nor "impinge on personal

rights protected by the Constitution," any stricter scrutiny is inappropriate. *Id.*

Although the Second Circuit found otherwise (J.A. 245), New York's ban on assisted suicide bears an obvious and rational relation to several important state interests, and thus is valid under the Equal Protection Clause. Indeed, the reasons underlying the State's legislative choice to prohibit rather than allow physician assisted suicide are more than legitimate; they are compelling.

A. New York Has a Legitimate, Indeed Compelling, Interest in the Prohibition of Intentional Killing and the Preservation of Life

As this Court observed in *Cruzan*, "a State may properly decline to make judgments about the 'quality' of life a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282.[10] In legislating to prohibit

[10] The Second Circuit asks: "What interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes" (J.A. 245). *See also Compassion in Dying*, 79 F.3d at 820 (state's interest in protecting life "is dramatically diminished if the person it seeks to protect is terminally ill"). But, one article asks, "[w]hy should the state's interest in preserving life diminish as life approaches its end? Are the lives of older persons or the terminally ill less 'valuable' to the state than the lives of those who may live indefinitely? And what is it that makes them less 'valuable'?" T. Marzen et al., *Suicide: A Constitutional Right*? 24 Duquesne L. Rev. 1, 103 (1985). If the basis for the supposedly diminished state interest is the diminished public value of the lives of the terminally ill, then the state likewise has a lessened interest in preserving the lives of "[a]ll 'burdensome,' 'noncontributing' persons—those who are 'valueless' to the state in the same sense as the very ill or old." *Id.* at 104. And if the basis for the diminished state interest instead resides in some notion that it is merciful to let the terminally ill die if they so choose, "then it is even more merciful to legitimize the same choice for many others whose lives may seem . . . equally devoid of meaning or filled with suffering, but will nevertheless be prolonged indefinitely." *Id.*

physician assisted suicide, a state can reasonably balance the societal desire for a state's citizens to achieve a death without prolonged suffering against any weakening of society's prohibition of intentional killing. "That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal." House of Lords, *Report from the Select Committee on Medical Ethics*, Session 1993-94, vol. I at 48. Unquestionably there are individual cases of real suffering, but "individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions." *Id.* This is an instance in which the "interest of the individual cannot be separated from the interest of society as a whole." *Id.*

The Second Circuit's decision effectively disregards New York's interest in the prohibition of intentional killing and the preservation of life. The decision purports to be carefully proscribed, extending only to the "prescribing [of] medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness" (J.A. 249). Yet predicated as it is on an equal protection framework that finds terminally ill patients "similarly situated" whether or not they are on life support, the very reasoning of the decision reveals its potential application to a far larger portion of the population.

The difficulty of containing the right to "hasten death," once recognized at all, is demonstrated by asking whether the right can readily be limited to the terminally ill. The problem is not merely one of definition, *see Developments in the Law—Medical Technology and the Law*, 103 Harvard L. Rev. 1519, 1644 n.11 (1990) ("[t]here is no generally accepted medical definition of 'terminal' "), or of explaining why a "terminal condition"[11] should have constitutional meaning, *see*

[11] This Court, in *United States v. Rutherford*, 442 U.S. 544 (1979), declined to exempt drugs to be used by terminally ill persons from FDA approval, because "under our constitutional framework, federal courts do not sit as councils of revision, empowered to rewrite legislation in accord

T. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 814-819 (1994). The entire basis for the right, according to the Second Circuit, is the similarity between terminally ill patients on life support and terminally ill patients who are not on life support. It is not merely the terminally ill, however, who have an essentially unqualified right to refuse or terminate life-sustaining treatment. As one state court observed, the right to refuse life-sustaining treatment is not "reserved to those suffering from terminal conditions." *Thor v. Superior Court*, 855 P.2d 375, 387 (Cal. 1993). Other state courts have repeatedly upheld the right of all competent individuals to refuse life-sustaining treatment. *See McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (respirator-dependent quadriplegic may terminate treatment); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989) (same); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (victim of severe cerebral palsy permitted to remove nasogastric feeding tube). *See generally* Y. Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Detroit Mercy L. Rev. 735, 740-43 (1995) ("If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide . . . doesn't someone who must continue to live what *she considers* an intolerable or unacceptable existence *for many years* have an equal—or even greater right to assisted suicide?") (emphasis in original).

Proponents of the right to assisted suicide, including one of the present plaintiff-physicians, have made clear their belief

with their own conceptions of prudent public policy." *Id.* at 555. *Cf. City of Cleburne*, 473 U.S. at 445 (declining to find that mentally retarded persons are a suspect class and stating that "it would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large. One need mention only the aging, the disabled, the mentally ill, and the infirm.").

that it is improper to limit the exercise of this right to the terminally ill. *See* T. Quill, *Death and Dignity* 162 (1993) (it is arbitrary to exclude victims of incurable but not terminal progressive illnesses); Note, *Who Decides If There Is " 'Triumph in the Ultimate Agony?' " Constitutional Theory and the Emerging Right to Die with Dignity*, 37 William & Mary L. Rev. 827, 893-95 (1996) (limiting the right to the terminally ill is constitutionally impermissible). And at least one proponent has acted on that belief. *See* G. Annas, *The "Right to Die" in America*, 34 Duquesne L. Rev. at 891 (describing Dr. Jack Kevorkian's assistance in the suicide of a patient in the early stages of Alzheimer's disease).

A second, separate inquiry moves from the terminally ill who want a physician to "prescrib[e] medications to be self-administered" by a patient (J.A. 249) to those who seek suicide but are unable to self-administer the lethal agents necessary to accomplish the act. Imagine, Professor Kamisar says, a person who is terminally ill and wishes to end her own life, but is physically unable

> to perform the last, death-causing act herself? . . . If the claim that one has, or ought to have, a right to control the time and manner of one's death is well founded—if one who is terminally ill has, or ought to have, the right to make the choice whether or not to go on living until death comes naturally—how can this right be denied to someone simply because she cannot swallow the barbiturates that will bring about death?

Kamisar, *Against Assisted Suicide*, 72 U. Detroit Mercy L. Rev. at 747. In one direction, then, the movement is from the terminally ill to the non-terminally ill; in another, it leads from physician assisted suicide to physician administered active euthanasia.

In addition, if a state approves physician assisted suicide and then also approves voluntary active euthanasia, under an equal protection analysis it may well next countenance non-

voluntary active euthanasia.[12] Many people who are incapable of requesting death might still be regarded as entitled to assistance in suicide. This follows, most obviously, from *Cruzan*, where the Court permitted an inquiry into an incompetent patient's expression of her wishes when she was competent. Under the Second Circuit's decision, if those wishes had included assisted suicide, it is difficult to see what principle would have prevented them from being honored. And in states which invoke a "best interests" standard in making treatment decisions for incompetent patients, *see, e.g.*, *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Cal. Ct. App. 1983) (where the choice the incompetent patient would have made with respect to prolonging his life cannot be ascertained, "the surrogate ought to be guided in his decision by the patient's best interests"), even the failure of an incompetent or never-competent patient to specify his desires with respect to physician assisted suicide will not be an obstacle to the exercise of this "right," for he may be viewed as similarly situated in all important respects to a terminally ill, competent patient who wants to ingest a lethal dose of drugs.[13]

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12 "Nonvoluntary" euthanasia is defined as "the euthanizing of incompetent patients or those who are unable to express their wishes." D. Callahan & M. White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Richmond L. Rev. 1, 42 (1996).

13 The experience of the Netherlands is instructive. While euthanasia is proscribed by the Dutch Penal Code, a series of judicial decisions since 1973 has enabled Dutch physicians to practice euthanasia and assisted suicide under certain circumstances. *See generally* Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 Emory Internat'l L. Rev. 255 (1996). A survey commissioned by the Dutch government showed that, out of a total of 129,000 deaths, there were 400 cases of assisted suicide, 2300 cases of active voluntary euthanasia, and 1000 cases of nonvoluntary euthanasia, apparently including more than 100 cases in which the patient was mentally competent. P. J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 The Lancet 669-674 (1991).

Thus, while the holding of the Second Circuit is narrow, the rationale upon which it rests demonstrates the great difficulty in containing the right to "hasten death," once any such "right" is recognized. The result is not only a failure to credit New York's legitimate interest in preventing intentional killing, but is also the improper substitution of a judicial determination for a legislative judgment.

As this Court has noted, a state is not required to equivocate when it articulates its interest in the protection and preservation of human life, but rather may legitimately assert an "unqualified interest" in life's preservation. *Cruzan*, 497 U.S. at 282. In the context of assisted suicide, that is precisely what New York has done. In fact, the State has taken a long and considered look at assisted suicide and at the distinction between assisted suicide and the refusal of treatment, the Legislature having visited the issues in enactments spanning two centuries.[14] The State's most recent statutory mention of assisted suicide came as part of the adoption by the New York Legislature of statutory provisions on health care proxies. N.Y. Pub. Health Law Art. 29-C (McKinney 1993). At that time, the Legislature made clear that nothing being added to the law was "intended to permit or promote suicide, assisted suicide or euthanasia," N.Y. Pub. Health Law § 2989(3) (McKinney 1993), and New York's penal provisions criminalizing assisted suicide were unambiguously left in place and not modified in any form.

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14 In 1788, New York recognized by statute the criminal common law, under which assisting suicide and assisting attempted suicide were crimes. Act of Feb. 21, 1788, ch. 37, § 2, 1788 N.Y. Laws 664, 665. In 1828, New York embodied its prohibition in its Penal Code. N.Y. Rev. Stat. pt. IV, ch. 1, tit.2, art. 1, § 7 (1829). The prohibition remained in place through a revision of the Penal Code in 1881. *See* N.Y. Penal L. tit. X, ch. 1, §§ 175, 176 (1882). The current provision dates from a complete revision, in 1965, of the criminal law in New York. 1965 N.Y. Laws c. 1030, codified at N.Y. Penal L. §§ 125.15(3), 120.30 (McKinney 1987). Under New York law, suicide itself is not a crime.

The substitution by the Second Circuit of its own "quality of life" judgment for that which was legislatively crafted was error. *See Heller v. Doe by Doe*, 509 U.S. 312, 319 (1993) (rational basis review " 'is not a license for courts to judge the wisdom, fairness, or logic of legislative choices,' " nor does it authorize " 'the judiciary [to] sit as a superlegislature' ") (citations omitted). When a legitimate governmental interest underlies a legislative act, the "calculus of effects, the manner in which a particular law reverberates in a society, is a legislative and not a judicial responsibility." *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 272 (1979). The Second Circuit's approach leaves no room for the quintessentially legislative act of achieving a "pragmatic compromise" between the societal desire "to respect patients' wishes, relieve suffering, and put an end to seemingly futile medical treatment" and the need "to maintain the salutary principle that the law protects all human life, no matter how poor its quality." Kamisar, *Against Assisted Suicide*, 72 U. Detroit Mercy L. Rev. at 758.[15] New York has, for its entire existence, struck the balance by prohibiting assisted suicide, *see* N.Y. Penal Law §§ 120.30, 125.15(3), while preserving for its citizens the common-law right to refuse life-sustaining treatment, *see Matter of Storar*, 420 N.E.2d 64, 70 (N.Y. 1981) (competent adult patient " 'has a right to determine what should be done with his own body' ") (quoting *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.)). The valuation of human life that underlies this legislative line-drawing is for the people of the State to determine. It is not a function to be preempted by the courts.

[15] The coming debate over the allocation of not just medical resources but resources of all kinds in the face of global overcrowding highlights the dubious, indeed illegitimate, nature of a substitution of judicial judgment for that of the elected representatives of a given state.

B. The State Has a Legitmate, Indeed Compelling, Interest in Preventing Abuse and Mistake

Not only did the Second Circuit neglect the validity of New York's considered legislative judgment, but it also discounted other state interests underlying New York's decision to prohibit physician assisted suicide. One such interest of paramount concern lies in the State's desire to prevent abuse. The New York State Task Force on the Life and the Law[16] explored this question thoroughly in a 1994 report on physician assisted suicide and euthanasia, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, in which it unanimously recommended rejection of proposals to legalize physician assisted suicide,[17] based upon the potential for abuse and mistake.

Among its observations, the Task Force noted:

[16] The New York State Task Force on Life and the Law was convened by Governor Mario M. Cuomo in 1985 to recommend public policy on health care decision-making issues raised by medical advances and new technologies. It is chaired by the State's Commissioner of Health, and its membership includes the State's Commissioner on the Quality of Care for the Mentally Disabled, physicians, nurses, academics, lawyers and representatives of various religious communities. New York State Task Force, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* i (1994). Since its inception, the Task Force has recommended public policy on a number of issues, including determination of death, the withdrawal and withholding of life-sustaining treatment, organ transplantation, the treatment of disabled newborns, and new practices to assist reproduction, and has issued reports and legislative proposals on, among other things, do-not-resuscitate orders and health care proxies. *Id.* at i, vii. *See also* New York State Task Force, *When Others Must Choose: Deciding for Patients Without Capacity* (1992); *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (1987); *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (1986).

[17] Among the proposals examined by the Task Force in reaching its conclusions was one co-authored by Dr. Timothy Quill, plaintiff herein. New York State Task Force, *When Death Is Sought* at 142.

> Assisted suicide and euthanasia would carry us into new terrain—American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill.

Id. at vii-viii. *See also id.* at viii ("the distinction between the refusal of medical treatment and assisted suicide and euthanasia has not been well-articulated in the broader public debate" and the "often-used rubric of the 'right to die' obscures" what are "critical distinctions"); Tribe, *American Constitutional Law* § 15-11 at 1370 ("[o]nce recognized, rights to die might be uncontainable and might prove susceptible to grave abuse").

As the Task Force stated, "[s]ome decisions to contribute to a patient's death may be well-intentioned but hasty and possibly mistaken. In other cases, patients may be pressured to consent to euthanasia when their care is expensive or burdensome to others." New York State Task Force, *When Death Is Sought* at 99. The Task Force likewise observed "that assisted suicide will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse . . . are the poor, minorities, and those who are least educated and least empowered." *Id.* at 125.

As recognized by the Task Force, *id.* at x, research suggests that suicide requests diminish when there is adequate control of pain and other symptoms, *see* K. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Assisted Suicide*, 6 J. Pain & Symptom Management 289, 290 (1991), and "excessive pain, discomfort and anxiety are nearly always examples of inadequate treatment," D. Shew-

mon, *Active Voluntary Euthanasia: A Needless Pandora's Box*, 3 Issues L. & Med. 219, 220 (1987). There is, moreover, evidence indicating that physicians do not always give or know how to give adequate relief of pain. *See* New York State Task Force, *When Death Is Sought* at 43 (only 12% of physicians rate their pain management training as excellent or good). "Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy." S. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey and the Right to Die*, 44 Am. U. L. Rev. 803, 841 (1995).

Moreover, it is not difficult to imagine that, given the inherent imbalance of power in the doctor-patient relationship, a doctor's suggestion of physician assisted suicide may be viewed not as the presentation of an option but as encouragement. *See, e.g.*, New York State Task Force, *When Death Is Sought* at 122 ("[t]hrough their tone, the encouragement they provide or withhold, and the way they present the information available, physicians can often determine the patient's choice"). This risk, obviously, is exacerbated for those "whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group," and who are likelier than others to suffer from inadequate pain relief. *Id.* at 120, 143. The coercive pressures which could surround the option of assisted suicide as a "medical treatment" cannot be underestimated. If the practice were to gain legal approval, physicians would presumably have a duty to inform patients fully about the option and, in response, some patients would likely feel there would be no alternative but to acquiesce, even if they would prefer to remain alive. *See id.* at 122 ("[e]ven assuming all physicians would act in good faith . . . physicians' recommendations would be a powerful fac-

tor in their patients' choices. Indeed, patients generally do what their doctors recommend").

The Second Circuit was mistaken in suggesting (J.A. 246-248) that New York's interest in protecting vulnerable patients from abuse is identical for patients who require life-sustaining treatment and those who consider physician assisted suicide. If the State prohibited patients from refusing unwanted medical treatment because of concerns about abuse, that could lead to the virtual enslavement of dying patients by tubes and invasive machinery, essentially mandating unwanted bodily interference. There is a difference between forcing invasive treatment on dying patients and helping them to kill themselves. Moreover, the nature and extent of the risk of abuse differs between the two populations. The risk of abuse with refusal of treatment is inherently limited: by definition, only people who require invasive treatment will die after refusing life-sustaining measures. By contrast, the risk of abuse and mistake with assisted suicide applies to every single person to whom the Second Circuit (or any other court) extends the "right."

Nor is the Second Circuit realistic in believing that New York can "establish rules and procedures to assure that all choices are free of such pressures" (J.A. 247). For one thing, there is the danger of error by physicians. No matter how many "safeguards" are proposed to accompany any legalization of assisted suicide, in practice all schemes of human governance are fallible, and mistakes are inevitable. The determination of who will be a "candidate" for assisted suicide depends upon a host of threshold decisions which must be made by physicians, all subject to fallible judgments, including determinations as to who is truly terminally ill, who is competent, who has a chance of recovery, and what is the proper course of pain management. All of these judgments are subject to the risk of misdiagnosis of the underlying illness or the failure to identify depression or other compromised mental state. *Cf. Addington v. Texas*, 441 U.S. 418, 430 (1979)

(the "nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations").

Moreover, the physician-patient relationship "is conducted in private and protected by the ethical and legal requirements of confidentiality," and is therefore "inherently inconsistent with on-site procedural regulation." Callahan & White, *The Legalization of Physician-Assisted Suicide*, 30 U. Richmond L. Rev. at 66. *See also* T. Quill, *Death and Dignity: A Case of Individualized Decisionmaking*, 324 New Eng. J. Med. 691 (1991) (first exposing Dr. Quill's suicide assistance, which would otherwise have remained unknown). As a practical matter, regulation of physician assisted suicide will be largely self-regulation by physicans. Callahan & White, *The Legalization of Physician Assisted Suicide*, at 10. *See Shapero v. Kentucky Bar Association*, 486 U.S. 466, 481 (1988) (O'Connor, J., dissenting) (courts should defer to "legislative function" of states in area of professional regulation); *Thornburgh v. American College of Obstetrics & Gynecology*, 476 U.S. 747, 803 (1986) (White, J., dissenting) ("the government is entitled not to trust members of a profession to police themselves").

In reaching a determination to prohibit physician assisted suicide, a state may also rely on the fact that this practice is not generally accepted by physicians themselves as an appropriate medical procedure. Despite the fact that the plaintiff-physicians in this case assert that assisted suicide is, in some cases, ethically proper from their own point of view, and even assuming that some other physicians would agree, assisted suicide by physicians remains contrary to the established ethics of the medical profession. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA at 2233 ("physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death"). There is simply no medical consensus in support of the practice, which has uniformly been regarded, to the present day, as out-

side the boundaries of acceptable medical procedure. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Physician-Assisted Suicide*, 10 Issues L. & Med. 91 (1994) (physician assisted suicide is inconsistent with the physician's professional role). It surely is not irrational for the State, as here, to recognize, in law, a limitation which is ethically and clinically established by the profession itself.

In essence, "[t]o make assisted suicide legal is to require each individual to justify (at least to herself) the decision to remain alive." Kreimer, *Does Pro-Choice Mean Pro-Kevorkian?*, 44 Am. U. L. Rev. at 816. The State of New York has a legitimate interest, as a matter of public policy, in shielding its citizens from the burden of performing this calculus. New York's choice to avoid the risks and complications inherent in embarking on the path opened by any legalization of assisted suicide is a permissible judgment for a state confronted with an issue of enormous complexity and far-reaching effect. New York's interests in preserving life and avoiding the abuses that arise in connection with assisted suicide are legitimate, and the relationship between these interests and a prohibition on assisted suicide is obvious. It is only to those who view the case as the Second Circuit did, and seek a justification for the difference between physician assisted suicide and what that court called "suicide through the withdrawal of life-sustaining treatment" (J.A. 246), that this will not be enough. Because it is erroneous, as a matter of history, law, medicine and logic, to treat these practices as the same thing, terminally ill individuals who wish to commit suicide with a physician's assistance are not similarly situated to terminally ill individuals who refuse or terminate life-sustaining medical treatment, and New York's different treatment of the two groups does not implicate the Equal Protection Clause.

CONCLUSION

Wherefore, Petitioners respectfully pray that the judgment of the United States Court of Appeals for the Second Circuit, entered April 2, 1996, be reversed insofar as it invalidated on equal protection grounds two New York State penal provisions that prohibit assisted suicide in all forms. That portion of the Second Circuit's decision which concluded that there is no fundamental liberty interest under the Due Process Clause to secure assistance in committing suicide should be upheld.

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